

10253

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Grantsville, Md.		c. LENGTH OF STAY IN 1b life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MELISSA BELLE BOUCHER		4. DATE OF DEATH Month Sept. Day 2 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 31, 1868
9. AGE (In years lost birthday) 91 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) Somerset Co., Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Walter H. Boucher		14. MOTHER'S MAIDEN NAME Elmira Lichliter	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none	
INFORMANT Miss Lucretia Boucher, Grantsville, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Chronic Myocarditis Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 10 yrs. 20 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1 June, 1946 to 1 Sept, 1959 , that I last saw the deceased alive on 1 Sept, 1959 , and that death occurred at 3 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Salisbury Pa ACTUAL SIGNATURE B H Hoke Jr. M.D. M.D. Salisbury Pa PHYSICIAN'S NAME (Type) B H Hoke Jr. M.D. SALISBURY PA			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 5, 1959	
22c. NAME OF CEMETERY OR CREMATORY Grantsville, Grantsville, Garrett Co., Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Don Newman		24a. REC'D BY REGISTRAR DATE SEP 8 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Kneiss			

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

UNITED STATES OF AMERICA

1950



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10237

Reg. Dist. No.

10254

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Lake Park, Md.			c. LENGTH OF STAY IN 1b minutes		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Deer Park		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) B. & O. RR. Crossing Mt. Lake Park, Md.				d. STREET ADDRESS /		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Janet Middle Marlene Last Deem				4. DATE OF DEATH Month 9 Day 10 Year 1959			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH 5/30/1947		9. AGE (In years last birthday) 12 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) student		10b. KIND OF BUSINESS OR INDUSTRY School		11. BIRTHPLACE (State or foreign country) Crellin, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Arthur Deem				14. MOTHER'S MAIDEN NAME Ruth Thelma Friend			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Ruth Deem Deer Park, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fractured skull DUE TO (b) 810X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH Immediate	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Stalled School Bus struck by B. & O. Train at Mt. Lake Park RR Crossing			
20c. TIME OF INJURY Month, Day, Year 8:24 a.m. Sept. 10 1959		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) RR Crossing		20f. (City or town) (County) (State) Mt. Lake Park Garrett Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE James H. Feaster, Jr.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 9-11-59			
EXAMINER'S NAME (Type) James H. Feaster, Jr., M. D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 9/12/1959		22c. NAME OF CEMETERY OR CREMATORY Deer Park Cemetery		22d. LOCATION (City, town, or county) (State) Deer Park Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Gerald N. Minnich Oakland, Maryland				24a. REC'D BY REGISTRAR SEP 16 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Knorr	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10255

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Garrett</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Garrett</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town.) <u>Mt. Lake Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Deer Park</u>	
c. LENGTH OF STAY IN lb <u>Minutes</u>		d. STREET ADDRESS <u>B. & O. RR Crossing Mt. Lake Park, Md.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>B. & O. RR Crossing Mt. Lake Park, Md.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Nancy</u> <u>Noami</u> <u>Deem</u>		4. DATE OF DEATH Month Day Year <u>9</u> <u>10</u> <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/30/1944</u>
9. AGE (In years last birthday) <u>14</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>School</u>	11. BIRTHPLACE (State or foreign country) <u>Mt. Lake Park, Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>James Arthur Deem</u>	
14. MOTHER'S MAIDEN NAME <u>Ruth Thelma Friend</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Ruth Deem Deer Park, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Internal injuries</u> DUE TO 810x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Fractured legs, compound</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Stalled School Bus struck by B. & O. Train at Mt. Lake Park RR Crossing</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> <u>Immediate</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Stalled School Bus struck by B. & O. Train at Mt. Lake Park RR Crossing</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>8:24</u> <u>pm</u> <u>Sept. 10</u> <u>1959</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> <u>RR Crossing</u>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Mt. Lake Park, Garrett Md.</u>		20f. (City or town) (County) (State) <u>Deer Park, Maryland</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>James H. Feaster, Jr.</u>		DATE SIGNED <u>9-11-59</u>	
EXAMINER'S NAME (Type) <u>James H. Feaster, Jr., M. D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>9/12/1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Deer Park Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Deer Park, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Gerald N. Minnich</u>		ADDRESS <u>Oakland, Maryland</u>	
24a. REC'D BY REGISTRAR <u>SEP 16 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. K...</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES H. [illegible]		2. SEX Male		3. AGE [illegible]		4. RACE [illegible]		5. BIRTH DATE [illegible]		6. BIRTH PLACE [illegible]		7. MARRIAGE DATE [illegible]		8. MARRIAGE PLACE [illegible]		9. DECEASED DATE [illegible]		10. DECEASED PLACE [illegible]		11. DECEASED TIME [illegible]		12. DECEASED TIME [illegible]	
13. DECEASED TIME [illegible]		14. DECEASED TIME [illegible]		15. DECEASED TIME [illegible]		16. DECEASED TIME [illegible]		17. DECEASED TIME [illegible]		18. DECEASED TIME [illegible]		19. DECEASED TIME [illegible]		20. DECEASED TIME [illegible]		21. DECEASED TIME [illegible]		22. DECEASED TIME [illegible]		23. DECEASED TIME [illegible]		24. DECEASED TIME [illegible]	
25. DECEASED TIME [illegible]		26. DECEASED TIME [illegible]		27. DECEASED TIME [illegible]		28. DECEASED TIME [illegible]		29. DECEASED TIME [illegible]		30. DECEASED TIME [illegible]		31. DECEASED TIME [illegible]		32. DECEASED TIME [illegible]		33. DECEASED TIME [illegible]		34. DECEASED TIME [illegible]		35. DECEASED TIME [illegible]		36. DECEASED TIME [illegible]	
37. DECEASED TIME [illegible]		38. DECEASED TIME [illegible]		39. DECEASED TIME [illegible]		40. DECEASED TIME [illegible]		41. DECEASED TIME [illegible]		42. DECEASED TIME [illegible]		43. DECEASED TIME [illegible]		44. DECEASED TIME [illegible]		45. DECEASED TIME [illegible]		46. DECEASED TIME [illegible]		47. DECEASED TIME [illegible]		48. DECEASED TIME [illegible]	
49. DECEASED TIME [illegible]		50. DECEASED TIME [illegible]		51. DECEASED TIME [illegible]		52. DECEASED TIME [illegible]		53. DECEASED TIME [illegible]		54. DECEASED TIME [illegible]		55. DECEASED TIME [illegible]		56. DECEASED TIME [illegible]		57. DECEASED TIME [illegible]		58. DECEASED TIME [illegible]		59. DECEASED TIME [illegible]		60. DECEASED TIME [illegible]	
61. DECEASED TIME [illegible]		62. DECEASED TIME [illegible]		63. DECEASED TIME [illegible]		64. DECEASED TIME [illegible]		65. DECEASED TIME [illegible]		66. DECEASED TIME [illegible]		67. DECEASED TIME [illegible]		68. DECEASED TIME [illegible]		69. DECEASED TIME [illegible]		70. DECEASED TIME [illegible]		71. DECEASED TIME [illegible]		72. DECEASED TIME [illegible]	
73. DECEASED TIME [illegible]		74. DECEASED TIME [illegible]		75. DECEASED TIME [illegible]		76. DECEASED TIME [illegible]		77. DECEASED TIME [illegible]		78. DECEASED TIME [illegible]		79. DECEASED TIME [illegible]		80. DECEASED TIME [illegible]		81. DECEASED TIME [illegible]		82. DECEASED TIME [illegible]		83. DECEASED TIME [illegible]		84. DECEASED TIME [illegible]	
85. DECEASED TIME [illegible]		86. DECEASED TIME [illegible]		87. DECEASED TIME [illegible]		88. DECEASED TIME [illegible]		89. DECEASED TIME [illegible]		90. DECEASED TIME [illegible]		91. DECEASED TIME [illegible]		92. DECEASED TIME [illegible]		93. DECEASED TIME [illegible]		94. DECEASED TIME [illegible]		95. DECEASED TIME [illegible]		96. DECEASED TIME [illegible]	
97. DECEASED TIME [illegible]		98. DECEASED TIME [illegible]		99. DECEASED TIME [illegible]		100. DECEASED TIME [illegible]		101. DECEASED TIME [illegible]		102. DECEASED TIME [illegible]		103. DECEASED TIME [illegible]		104. DECEASED TIME [illegible]		105. DECEASED TIME [illegible]		106. DECEASED TIME [illegible]		107. DECEASED TIME [illegible]		108. DECEASED TIME [illegible]	
109. DECEASED TIME [illegible]		110. DECEASED TIME [illegible]		111. DECEASED TIME [illegible]		112. DECEASED TIME [illegible]		113. DECEASED TIME [illegible]		114. DECEASED TIME [illegible]		115. DECEASED TIME [illegible]		116. DECEASED TIME [illegible]		117. DECEASED TIME [illegible]		118. DECEASED TIME [illegible]		119. DECEASED TIME [illegible]		120. DECEASED TIME [illegible]	

RECEIVED
 1911
 10310037492400

CERTIFICATE OF DEATH

Reg. Dist. No.

10256

1. PLACE OF DEATH o. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Grantsville.		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First RUTH Middle OLIVE Last DURST		4. DATE OF DEATH Month Sept. Day 5 Year 1959	
5. SEX Female.	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 14, 1893
9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) Grantsville, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Patton		14. MOTHER'S MAIDEN NAME Mollie Fuller	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Emma Jean Lohr, Grantsville, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic myocardial failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic heart disease DUE TO (c) Hypertension PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 5 years 10 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 24, 1955 to Sept. 5, 1959 , that I last saw the deceased alive on Sept. 3, 1959 , and that death occurred at 3 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Grantsville, Md. DATE SIGNED 9/5/59			
ACTUAL SIGNATURE G. Paige Strong M.D.		DATE SIGNED 9/5/59	
PHYSICIAN'S NAME (Type) A. PAIGE STRONG		GRANTSVILLE MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/7/59	22c. NAME OF CEMETERY OR CREMATORY Grantsville	22d. LOCATION (City, town, or county) (State) Grantsville, Garrett Co., Md.
23. FUNERAL DIRECTOR'S SIGNATURE Don J. Newman		24a. REC'D BY REGISTRAR SEP 9 '59	24b. REGISTRAR'S SIGNATURE Arthur L. Harris

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

0228



10257

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY GARRETT COUNTY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WEST VIRGINIA Maryland, Garrett b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND, MARYLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) INDEPENDENCE Sang Run, rural	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First FRANKLIN Middle T. Last FRANTZ		4. DATE OF DEATH Month SEPTEMBER Day 2 Year 1959	
5. SEX MALE	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-28-1883
9. AGE (In years last birthday) yrs. 75		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) COUNTY ROADS WORKER		10b. KIND OF BUSINESS OR INDUSTRY ROAD MAINTENANCE	
11. BIRTHPLACE (State or foreign country) FRIENDSVILLE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME WILLIAM FRANTZ		14. MOTHER'S MAIDEN NAME ELIZA FIKE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT MRS. MAE DE WITT		Address MT. LAKE PARK, MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 Uremia - Progressive DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Pyelonephritis DUE TO (c) Arteriosclerotic Cardiovascular Disease			INTERVAL BETWEEN ONSET AND DEATH Unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Aug 31, 1959 to Sept 2, 1959 , that I last saw the deceased alive on Sept 2, 1959 , and that death occurred at 9:10 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Herbert F. Leighton M.D.		ADDRESS (Street, city or town, State) 77 Oak St., Oakland, Md. DATE SIGNED 3 Sept 59	
PHYSICIAN'S NAME (Type) DR. HERBERT LEIGHTON		OAKLAND, MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/5/1959	22c. NAME OF CEMETERY OR CREMATORY Oak Grove Cemetery	22d. LOCATION (City, town, or county) (State) near McHenry, Md.
23. FUNERAL DIRECTOR'S SIGNATURE H. C. Leighton		ADDRESS Oakland, Md.	24a. REC'D BY REGISTRAR SEP 8 '59
		24b. REGISTRAR'S SIGNATURE Arthur S. K...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

22 23

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10241

Reg. Dist. No.

10258

1. PLACE OF DEATH a. COUNTY <u>Garrett</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Lake Park</u> c. LENGTH OF STAY IN 1b <u>minutes</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Garrett</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Star Route, Oakland</u> d. STREET ADDRESS <u>/</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Charles</u> First <u>Andrew</u> Middle <u>Friend</u> Last				4. DATE OF DEATH Month <u>9</u> Day <u>26</u> Year <u>19 59</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>June 20, 1920</u>			
9. AGE (In years last birthday) <u>39</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>part-time farming</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>Edmond Friend</u>				
14. MOTHER'S MAIDEN NAME <u>Tillie C. Knox</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				
16. SOCIAL SECURITY NO. <u>none</u>			17. INFORMANT <u>Elizabeth Knox</u> Address <u>Star Rt. Oakland, Md.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>1. Fracture body 6th cerv. vert. 2. Compound fracture right tibia & fibula (distal portion) 3. Devere</u> DUE TO <u>812X</u> <u>abrasions & contusions right scapular area of back,</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <u>lower right thorax 4. Prob. skull fracture.</u> (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Stuck by automobile.</u>		20c. TIME OF INJURY Month, Day, Year <u>7:30 a.m. 9/26/ 19 59</u>					
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Mt. Lake Park Rd. Mt. Lake Park Garrett Md.</u>					
20f. (City or town) <u>Garrett</u>		(County) <u>Md.</u>					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <u>E. Irving Baumgartner</u> M.D.				DATE SIGNED <u>9/28/59</u>			
EXAMINER'S NAME (Type) <u>E. Irving Baumgartner, M.D.</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>9/29/1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glendale Cemetery</u>			
22d. LOCATION (City, town, or county) <u>Garrett, Maryland</u>		(State)					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Minnich Funeral Home</u> ADDRESS <u>Oakland, Md.</u>				24a. REC'D BY REGISTRAR <u>DATE OCT 2 '59</u>			
24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>							

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10242

Reg. Dist. No.

10259

1. PLACE OF DEATH a. COUNTY Garrett b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland,		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland. b. COUNTY Garrett c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Bloomington	
c. LENGTH OF STAY IN 1b one hour		d. STREET ADDRESS 5 Mi. West Bloomington	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Garrett County Mem. Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First James Middle Clyde Last Harvey		4. DATE OF DEATH Month September Day 14 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH Feb. 13, 1898	9. AGE (In years last birthday) 61 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Coal Miner & Laborer		10b. KIND OF BUSINESS OR INDUSTRY Road construction	11. BIRTHPLACE (State or foreign country) Maryland.
13. FATHER'S NAME Tilden R. Harvey		14. MOTHER'S MAIDEN NAME Annie Tasker	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. 281-12-0430	
17. INFORMANT Mrs. James C. Harvey		Address Bloomington, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial thrombosis, acute 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Known hypertensive			INTERVAL BETWEEN ONSET AND DEATH Immediate
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE James H. Feaster Jr.		DATE SIGNED 9-15-59	
EXAMINER'S NAME (Type) James H. Feaster Jr., M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/17/1959	22c. NAME OF CEMETERY OR CREMATORY Deer Park Cemetery	22d. LOCATION (City, town, or county) (State) Deer Park, Md.
23. FUNERAL DIRECTOR'S SIGNATURE H. L. Leighton		24a. REC'D BY REGISTRAR SEP 18 '59	
ADDRESS Oakland, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10243

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Garrett</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Garrett</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Lake Park,</u>		c. LENGTH OF STAY IN 1b <u>minutes</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Deer Park</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>B & O R. R. Crossing, Mt. Lake Park</u>				d. STREET ADDRESS <u>3 Mi. West</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Merle</u> Middle <u>B.</u> Last <u>Harvey Jr.</u>				4. DATE OF DEATH Month <u>September</u> Day <u>10</u> , Year <u>19 59</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> B. DATE OF BIRTH <u>Aug. 3, 1948</u>		9. AGE (In years last birthday) <u>11</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Merle B. Harvey</u>				14. MOTHER'S MAIDEN NAME <u>Arlene Shunk</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>Mrs. Shirley Wright</u> Address <u>Deer Park, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fractured Skull</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause last. DUE TO _____							INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Stalled school bus struck by train at B. & O. RR Crossing, Mt. Lake Park, Md.</u>			
20c. TIME OF INJURY Month, Day, Year <u>8:24 a.m. Sept. 10 1959</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>RR Crossing</u>		20f. (City or town) (County) (State) <u>Mt. Lake Park, Garr. Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>James H. Feaster, Jr.</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) <u>James H. Feaster, Jr., M. D.</u>				DATE SIGNED <u>9-11-59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/13/1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ferndale Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>near Oakland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. C. Reighton</u>				ADDRESS <u>Oakland, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 14 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kenna</u>							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10244

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Garrett</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Lake Park</u> c. LENGTH OF STAY IN 1b <u>Minutes</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>B & O. R. R. Crossing, Mt. Lake Park</u>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Garrett</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Rural Deer Park,</u> d. STREET ADDRESS <u>3 Mi. West</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Nancy Lee</u> Middle <u>Harvey</u> Last <u>Harvey</u>		4. DATE OF DEATH Month <u>September</u> Day <u>10</u> , Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 17, 1947</u>
9. AGE (In years last birthday) <u>12</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Merle B. Harvey</u>		14. MOTHER'S MAIDEN NAME <u>Arlene Shunk</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>----</u>	
17. INFORMANT <u>Mrs. Shirley Wright</u>		Address <u>Deer Park, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fractured skull</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Broken Arms</u> DUE TO (c) <u> </u> </div> <div style="width: 15%; text-align: center;"> INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> <u>Immediate</u> </div> </div>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>Struck by train</u>	
20c. TIME OF INJURY Month, Day, Year <u>8:24</u> <u>Sept. 10</u> <u>1959</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>RR Crossing</u>		20f. (City or town) (County) (State) <u>Mt. Lake Park Garrett Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>James H. Feaster, Jr.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>James H. Feaster, Jr. M. D.</u>		DATE SIGNED <u>9-11-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/13/1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Ferndale Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>near Oakland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Leighton</u>		ADDRESS <u>Oakland, Md.</u>	
24a. REC'D BY REGISTRAR <u>SEP 14 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

10262

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crellin		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crellin	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) William Lawson Henline		4. DATE OF DEATH Month Sept. Day 28, Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 19, 1879
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sawyer		10b. KIND OF BUSINESS OR INDUSTRY Saw Mill	
11. BIRTHPLACE (State or foreign country) W.Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Arch Henline		14. MOTHER'S MAIDEN NAME Martha Shaffer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 213-01-5660	
17. INFORMANT Mrs. Nora Henline		Address Crellin, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Heart Disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 2 years 10 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1/8/ 19 55 , to 9/28/ 19 59 , that I last saw the deceased alive on 9/28/ 19 59 , and that death occurred at 6:45 AM from the causes and on the date stated above.			
ACTUAL SIGNATURE A. E. Mance		ADDRESS (Street, city or town, state) 101 Third Street	
PHYSICIAN'S NAME (Type) A. E. MANCE, M.D.		DATE SIGNED 9/29/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 1, 1959	
22c. NAME OF CEMETERY OR CREMATORY Eglon		22d. LOCATION (City, town, or county) (State) Eglon W.Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Wayne C. Spizzle Davis, W.Va.		24a. REC'D BY REGISTRAR DATE 2 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Hance			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10246

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

10263

1. PLACE OF DEATH a. COUNTY <u>Garrett</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Garrett</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oakland,</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>1 hr. 15 mi. X Rural Mt. Lake Park,</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Garrett County Memorial Hospital</u>		d. STREET ADDRESS <u>1 Mi. South</u>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Richard</u> Middle <u>Lynn</u> Last <u>Hinkle</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>10,</u> Year <u>19 59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 16, 1948</u>
9. AGE (In years last birthday) <u>11</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Roy Olen Hinkle</u>		14. MOTHER'S MAIDEN NAME <u>Norma Liller</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Roy O. Hinkle</u>		Address <u>Mt. Lake Park, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crushed Chest</u> <u>810X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u> </u> (c) <u> </u> DUE TO stating the underlying cause lost. DUE TO DUE TO			INTERVAL BETWEEN ONSET AND DEATH <u>1hr 15 mins.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter date of injury last, P.M.U. or Item 1.) <u>Stalled School Bus struck by train at B. & O. RR. Crossing, Mt. Lake Park, Md.</u>	
20c. TIME OF INJURY Month, Day, Year <u>8:24</u> <u>xx</u> <u>Sept 10</u> <u>19 59</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>RR Crossing</u>		20f. (City or town) (County) (State) <u>Mt. Lake Park Garr. Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>James H. Feaster, Jr.</u>		DATE SIGNED <u>9-11-59</u>	
EXAMINER'S NAME (Type) <u>James H. Feaster, Jr. M. D.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Sept. 13, 59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Oakland Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Oakland, Maryland.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>A.C. Leighton</u>		24a. REC'D BY REGISTRAR <u>SEP 14 '59</u>	
ADDRESS <u>Oakland, Md.</u>		24b. REGISTRAR'S SIGNATURE <u> </u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON MEDICAL EXAMINER'S CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED: _____</p>		<p>2. SEX: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE</p>	
<p>3. AGE: _____</p>		<p>4. DATE OF BIRTH: _____</p>	
<p>5. PLACE OF BIRTH: _____</p>		<p>6. OCCUPATION: _____</p>	
<p>7. MARITAL STATUS: <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED</p>		<p>8. PRESENT ADDRESS: _____</p>	
<p>9. CAUSE OF DEATH: _____</p>		<p>10. MANNER OF DEATH: <input type="checkbox"/> NATURAL <input type="checkbox"/> ACCIDENTAL <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE</p>	
<p>11. SIGNATURE OF MEDICAL EXAMINER: _____</p>		<p>12. SIGNATURE OF DECEASED: _____</p>	
<p>13. DATE OF EXAMINATION: _____</p>		<p>14. TIME OF EXAMINATION: _____</p>	
<p>15. PLACE OF EXAMINATION: _____</p>		<p>16. SIGNATURE OF WITNESS: _____</p>	
<p>17. SIGNATURE OF DECEASED: _____</p>		<p>18. SIGNATURE OF WITNESS: _____</p>	
<p>19. SIGNATURE OF DECEASED: _____</p>		<p>20. SIGNATURE OF WITNESS: _____</p>	
<p>21. SIGNATURE OF DECEASED: _____</p>		<p>22. SIGNATURE OF WITNESS: _____</p>	
<p>23. SIGNATURE OF DECEASED: _____</p>		<p>24. SIGNATURE OF WITNESS: _____</p>	
<p>25. SIGNATURE OF DECEASED: _____</p>		<p>26. SIGNATURE OF WITNESS: _____</p>	
<p>27. SIGNATURE OF DECEASED: _____</p>		<p>28. SIGNATURE OF WITNESS: _____</p>	
<p>29. SIGNATURE OF DECEASED: _____</p>		<p>30. SIGNATURE OF WITNESS: _____</p>	
<p>31. SIGNATURE OF DECEASED: _____</p>		<p>32. SIGNATURE OF WITNESS: _____</p>	
<p>33. SIGNATURE OF DECEASED: _____</p>		<p>34. SIGNATURE OF WITNESS: _____</p>	
<p>35. SIGNATURE OF DECEASED: _____</p>		<p>36. SIGNATURE OF WITNESS: _____</p>	
<p>37. SIGNATURE OF DECEASED: _____</p>		<p>38. SIGNATURE OF WITNESS: _____</p>	
<p>39. SIGNATURE OF DECEASED: _____</p>		<p>40. SIGNATURE OF WITNESS: _____</p>	
<p>41. SIGNATURE OF DECEASED: _____</p>		<p>42. SIGNATURE OF WITNESS: _____</p>	
<p>43. SIGNATURE OF DECEASED: _____</p>		<p>44. SIGNATURE OF WITNESS: _____</p>	
<p>45. SIGNATURE OF DECEASED: _____</p>		<p>46. SIGNATURE OF WITNESS: _____</p>	
<p>47. SIGNATURE OF DECEASED: _____</p>		<p>48. SIGNATURE OF WITNESS: _____</p>	
<p>49. SIGNATURE OF DECEASED: _____</p>		<p>50. SIGNATURE OF WITNESS: _____</p>	
<p>51. SIGNATURE OF DECEASED: _____</p>		<p>52. SIGNATURE OF WITNESS: _____</p>	
<p>53. SIGNATURE OF DECEASED: _____</p>		<p>54. SIGNATURE OF WITNESS: _____</p>	
<p>55. SIGNATURE OF DECEASED: _____</p>		<p>56. SIGNATURE OF WITNESS: _____</p>	
<p>57. SIGNATURE OF DECEASED: _____</p>		<p>58. SIGNATURE OF WITNESS: _____</p>	
<p>59. SIGNATURE OF DECEASED: _____</p>		<p>60. SIGNATURE OF WITNESS: _____</p>	
<p>61. SIGNATURE OF DECEASED: _____</p>		<p>62. SIGNATURE OF WITNESS: _____</p>	
<p>63. SIGNATURE OF DECEASED: _____</p>		<p>64. SIGNATURE OF WITNESS: _____</p>	
<p>65. SIGNATURE OF DECEASED: _____</p>		<p>66. SIGNATURE OF WITNESS: _____</p>	
<p>67. SIGNATURE OF DECEASED: _____</p>		<p>68. SIGNATURE OF WITNESS: _____</p>	
<p>69. SIGNATURE OF DECEASED: _____</p>		<p>70. SIGNATURE OF WITNESS: _____</p>	
<p>71. SIGNATURE OF DECEASED: _____</p>		<p>72. SIGNATURE OF WITNESS: _____</p>	
<p>73. SIGNATURE OF DECEASED: _____</p>		<p>74. SIGNATURE OF WITNESS: _____</p>	
<p>75. SIGNATURE OF DECEASED: _____</p>		<p>76. SIGNATURE OF WITNESS: _____</p>	
<p>77. SIGNATURE OF DECEASED: _____</p>		<p>78. SIGNATURE OF WITNESS: _____</p>	
<p>79. SIGNATURE OF DECEASED: _____</p>		<p>80. SIGNATURE OF WITNESS: _____</p>	
<p>81. SIGNATURE OF DECEASED: _____</p>		<p>82. SIGNATURE OF WITNESS: _____</p>	
<p>83. SIGNATURE OF DECEASED: _____</p>		<p>84. SIGNATURE OF WITNESS: _____</p>	
<p>85. SIGNATURE OF DECEASED: _____</p>		<p>86. SIGNATURE OF WITNESS: _____</p>	
<p>87. SIGNATURE OF DECEASED: _____</p>		<p>88. SIGNATURE OF WITNESS: _____</p>	
<p>89. SIGNATURE OF DECEASED: _____</p>		<p>90. SIGNATURE OF WITNESS: _____</p>	
<p>91. SIGNATURE OF DECEASED: _____</p>		<p>92. SIGNATURE OF WITNESS: _____</p>	
<p>93. SIGNATURE OF DECEASED: _____</p>		<p>94. SIGNATURE OF WITNESS: _____</p>	
<p>95. SIGNATURE OF DECEASED: _____</p>		<p>96. SIGNATURE OF WITNESS: _____</p>	
<p>97. SIGNATURE OF DECEASED: _____</p>		<p>98. SIGNATURE OF WITNESS: _____</p>	
<p>99. SIGNATURE OF DECEASED: _____</p>		<p>100. SIGNATURE OF WITNESS: _____</p>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10247

Reg. Dist. No.

10264

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Garrett			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 11. Lake Park B & O RR CROSSING Minutes				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural Deer Park			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				/d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Lee First Carl Middle HOFFMAN Last				4. DATE OF DEATH Month 9 Day 10 Year 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/6/1948		9. AGE (In years last birthday) 11 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) student		10b. KIND OF BUSINESS OR INDUSTRY school		11. BIRTHPLACE (State or foreign country) Cleveland, Ohio		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Raymond Hoffman				14. MOTHER'S MAIDEN NAME Jean Reamy			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Raymond Hoffman Rural Deer Park, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fractured skull DUE TO (b) Broken left leg Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO (c) 810X							INTERVAL BETWEEN ONSET AND DEATH Immediate Immediate
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II if item 18.) Stalled School Bus struck by B. & O. Train at Mt. Lake Park RR Crossing					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 8:24 p.m. Sept. 10 1959		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) RR Crossing		20f. (City or town) (County) (State) Mt. Lake Park Garrett Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>James H. Feaster, Jr.</i> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) James H. Feaster, Jr., M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/> 9-11-59			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 9/13/1959		22c. NAME OF CEMETERY OR CREMATORY Oakland Cemetery		22d. LOCATION (City, town, or county) (State) Oakland Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Gerald W. Minnich				ADDRESS Oakland, Maryland		24a. REC'D BY REGISTRAR SEP 16 '59	
				24b. REGISTRAR'S SIGNATURE <i>Arthur E. Kraus</i>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION		6. PLACE OF BIRTH		7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF EXAMINER		13. DATE			
14. DISEASE OR INJURY		15. HISTORY		16. PHYSICAL EXAMINATION		17. LABORATORY EXAMINATIONS		18. POST-MORTEM FINDINGS		19. OTHER FINDINGS		20. COMMENTS		21. SIGNATURE OF EXAMINER		22. DATE		23. SIGNATURE OF EXAMINER		24. DATE		25. SIGNATURE OF EXAMINER		26. DATE			
27. SIGNATURE OF EXAMINER		28. DATE		29. SIGNATURE OF EXAMINER		30. DATE		31. SIGNATURE OF EXAMINER		32. DATE		33. SIGNATURE OF EXAMINER		34. DATE		35. SIGNATURE OF EXAMINER		36. DATE		37. SIGNATURE OF EXAMINER		38. DATE		39. SIGNATURE OF EXAMINER		40. DATE	

BALTIMORE
 DEPARTMENT OF HEALTH
 DIVISION OF VITAL RECORDS
 100 NORTH CALVERT STREET
 BALTIMORE, MARYLAND 21202

1

Reg. Dist. No.

10248

10265

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL GRANTSVILLE		c. LENGTH OF STAY IN 1b 1 DAY	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) DENISE ANN HUMMEL		4. DATE OF DEATH Month SEPT Day 22 Year 1959	
5. SEX FEMALE		6. COLOR OR RACE WHITE	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH SEPT 17 1939	
9. AGE (In years last birthday) yrs 19		10. IF UNDER 1 YEAR Months 5 Days 5 Hours 15 Min. 15	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		12. KIND OF BUSINESS OR INDUSTRY NONE	
13. BIRTHPLACE (State or foreign country) MEYERSDALE, PENNSYLVANIA		14. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. FATHER'S NAME HARRY W. HUMMEL		16. MOTHER'S MAIDEN NAME RHODA SHUMAKER	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		18. SOCIAL SECURITY NO. NONE	
19. INFORMANT Mr. Harry W. Hummel, Grantsville, MD		20. ADDRESS Grantsville, Garrett Co, MD	
21. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 921.0 DUE TO bronchial obstruction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) aspiration of vomitus DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		22. INTERVAL BETWEEN ONSET AND DEATH 15 min 15 min	
23a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		23b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Probably vomited while sleeping	
24a. TIME OF INJURY Hour 4:00 4:00 9-22-59 Month, Day, Year		24b. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
24c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		24d. (City or town) (County) (State) Grantsville Garrett Md	
25. I certify that I attended the deceased from Sept 17 1959 to Sept 22 1959 , that I last saw the deceased alive on Sept 20 1959 and that death occurred at 5:00 PM , from the causes and on the date stated above.		26. ADDRESS (Street, city or town, state) Meyersdale, Pa DATE SIGNED	
27. ACTUAL SIGNATURE Ron Rumbig		28. PHYSICIAN'S NAME (Type) Arthur E. Thomas	
29a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		29b. DATE THEREOF 9/23/59	
29c. NAME OF CEMETERY OR CREMATORY TRINITY REFORM		29d. LOCATION (City, town, or county) (State) GRANTSVILLE GARRETT CO MD	
30. FUNERAL DIRECTOR'S SIGNATURE Ron Rumbig		31. ADDRESS GRANTSVILLE, MD	
32a. REC'D BY REGISTRAR DATE SEP 28 '59		32b. REGISTRAR'S SIGNATURE Arthur E. Thomas	

VS A15 (4)
15M 9/58

VS A15 (4)
15M 9/5B

STATE OF TEXAS
DEPARTMENT OF HEALTH

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CERTIFICATE OF DEATH

Reg. Dist. No.

10249

10266

1. PLACE OF DEATH a. COUNTY <u>Garrett</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Garrett</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oakland,</u>		c. LENGTH OF STAY IN 1b <u>4 Wks.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Rural Deer Park,</u>		d. STREET ADDRESS <u>1/4 Mi. North</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Garrett County Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Nellie</u> Middle <u>Enlow</u> Last <u>Lashorn</u>		4. DATE OF DEATH Month <u>September</u> Day <u>20</u> , Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 23, 1882</u>
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>David T. Enlow</u>	
14. MOTHER'S MAIDEN NAME <u>Lavina Wilkins</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	
16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT J. C. Lashorn Deer Park, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO <u>Arteriosclerotic Cardiovascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u> <u>Unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cholelithiasis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u> </u> <u> </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8/26</u> , 19 <u>59</u> , to <u>9/20</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>9/20</u> , 19 <u>59</u> , and that death occurred at <u>1:55P</u> M, from the causes and on the date stated above.		21. I certify that I attended the deceased from <u>8/26</u> , 19 <u>59</u> , to <u>9/20</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>9/20</u> , 19 <u>59</u> , and that death occurred at <u>1:55P</u> M, from the causes and on the date stated above.	
ACTUAL SIGNATURE <u>Herbert H. Leighton</u>		ADDRESS (Street, city or town, state) <u>77 Oak St., Oakland, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Herbert H. Leighton, M. D.</u>		DATE SIGNED <u>21 Sept 59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/23/1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Deer Park Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Deer Park, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. C. Leighton</u>		ADDRESS <u>Oakland, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>SEP 24 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur J. Knauer</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF CORRECTIONS - BALTIMORE 18

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10250

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Garrett</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Garrett</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Lake Park</u>		c. LENGTH OF STAY IN 1b <u>Minutes</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Deer Park</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>B. & O. RR. Crossing, Mt. Lake Park, Md.</u>				d. STREET ADDRESS 			
3. NAME OF DECEASED (Type or print) First <u>Shirley</u> Middle <u>Ann</u> Last <u>Lee</u>				4. DATE OF DEATH Month <u>9</u> Day <u>10</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/10/1947</u>		9. AGE (in years last birthday) <u>12</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>School</u>		11. BIRTHPLACE (State or foreign country) <u>Gorman, W. Va.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Joseph Lee</u>			14. MOTHER'S MAIDEN NAME <u>Evelyn Virginia Lee</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Henry Lee Deer Park, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fractured skull</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Stalled school bus struck by B. & O. train at Mt. Lake Park Crossing.</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>8:24</u> a. m. <u>Sept. 10</u> 19 <u>59</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>RR Crossing</u>			
20f. (City or town) <u>Mt. Lake Park</u>		20g. (County) <u>Garrett</u>		20h. (State) <u>Md.</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <u>James H. Feaster, Jr.</u>			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
EXAMINER'S NAME (Type) <u>James H. Feaster, Jr., M. D.</u>			DATE SIGNED <u>9-11-59</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>9/13/ 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove Cemetery</u>			
22d. LOCATION (City, town, or county) <u>Gorman</u>		22e. (State) <u>Maryland</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Gerald N. Minnich</u>			ADDRESS <u>Oakland, Maryland</u>				
24a. REC'D BY REGISTRAR DATE <u>SEP 16 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>					

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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10268

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 6, 13 & 14 Film G249 10/5/59 1wk

CERTIFICATE OF DEATH

Reg. Dist. No. 10251

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport 01-43-2	
c. LENGTH OF STAY IN 1b 3 Yrs		d. STREET ADDRESS Philos Ave.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Weeks Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ROBERT MARTIN		4. DATE OF DEATH 9 25 19 59	
5. SEX White		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 11, 1884	
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sexton		10b. KIND OF BUSINESS OR INDUSTRY Cemetery	
11. BIRTHPLACE (State or foreign country) Westernport, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert Martin, Sr.		14. MOTHER'S MAIDEN NAME Emma Wright	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 0	
17. INFORMANT Ernest Martin Westernport, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary edema 450.0 DUE TO Arteriosclerosis, generalized Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) years DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchial asthma, chronic			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-3-57 , 19____, to 9-19-59 , 19____, that I last saw the deceased alive on 9-19-59 , 19____, and that death occurred at 1:30 A. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 58 2nd. St., Oakland, Md. DATE SIGNED 9-27-59 ACTUAL SIGNATURE James H. Feaster, Jr. M.D. PHYSICIAN'S NAME (Type) JAMES H. FEASTER, JR., M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/29/59	
22c. NAME OF CEMETERY OR CREMATORY Philos		22d. LOCATION (City, town, or county) (State) Westernport, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE E. J. B. B. ADDRESS Westernport, Md.		24a. REC'D BY REGISTRAR SEP 30 '59 24b. REGISTRAR'S SIGNATURE Arthur E. Hanna	

CERTIFICATE OF DEATH

Dec 10, 1918

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION	
JAMES H. HARRIS		Male		35		White		Laborer	
6. PLACE OF BIRTH		7. PLACE OF DEATH		8. DATE OF DEATH		9. TIME OF DEATH		10. CAUSE OF DEATH	
Baltimore, Md.		Baltimore, Md.		Dec 10, 1918		10:30 AM		Pneumonia	
11. NAME OF PHYSICIAN		12. NAME OF BURIAL PLACE		13. NAME OF FUNERAL HOME		14. NAME OF MINISTER		15. NAME OF WITNESSES	
Dr. J. H. Smith		Greenwood Cemetery		Harris & Sons		Rev. J. H. Jones		J. H. Smith, J. H. Jones	
16. SIGNATURE OF PHYSICIAN		17. SIGNATURE OF BURIAL PLACE		18. SIGNATURE OF FUNERAL HOME		19. SIGNATURE OF MINISTER		20. SIGNATURE OF WITNESSES	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	



THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH, BALTIMORE, MARYLAND, DECEMBER 10, 1918.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10269

CERTIFICATE OF DEATH

Reg. Dist. No.

10252

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bloomington				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bloomington			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 1			
3. NAME OF DECEASED (Type or print) First William Dorsey Middle Pattison Last Pattison				4. DATE OF DEATH Month September Day 4 Year 19 59			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 4, 1889	
9. AGE (In years last birthday) 70		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0		11. IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Postmaster				10b. KIND OF BUSINESS OR INDUSTRY Bloomington, Md.		11. BIRTHPLACE (State or foreign country) U.S.A.	
13. FATHER'S NAME George C. Pattison				14. MOTHER'S MAIDEN NAME Iola Kildow			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 214-323344		17. INFORMANT William D. Pattison Jr. Bloomington, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Blood loss (hemorrhage) 161X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cancer of the larynx DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH Several years 3 to 5			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from November , 19 58 , to Sept 3 , 19 59 , that I last saw the deceased alive on Sept 3 , 19 59 , and that death occurred at 2:45 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 84 Main St., Westernport, Md. DATE SIGNED 9-5-59							
ACTUAL SIGNATURE William W. Lesh M.D.				PHYSICIAN'S NAME (Type) William W. Lesh, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Sept. 6, 1959		22c. NAME OF CEMETERY OR CREMATORY Philos	
22d. LOCATION (City, town, or county) (State) Westernport, Md.							
23. FUNERAL DIRECTOR'S SIGNATURE W. Fredlock Jr.				ADDRESS Piedmont, W. Va.		24a. REC'D BY REGISTRAR DATE SEP 10 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Hines							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

20250

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

<p>NAME OF DECEASED William C. Johnson</p>		<p>DATE OF BIRTH 1-15-1900</p>	
<p>PLACE OF BIRTH St. Louis, Mo.</p>		<p>DATE OF DEATH 1-25-1950</p>	
<p>RESIDENCE 1234 N. Broadway, Baltimore, Md.</p>		<p>CAUSE OF DEATH Myocardial Infarction</p>	
<p>DATE OF DEATH 1-25-1950</p>		<p>PLACE OF DEATH Home</p>	
<p>TIME OF DEATH 10:15 AM</p>		<p>SEX Male</p>	
<p>AGE 50</p>		<p>HEIGHT 5' 8"</p>	
<p>WEIGHT 175</p>		<p>HAIR Dark</p>	
<p>EYES Blue</p>		<p>SKIN Fair</p>	
<p>EDUCATION High School</p>		<p>OCCUPATION Engineer</p>	
<p>MARRIAGE Married</p>		<p>RELIGION Methodist</p>	
<p>PREVIOUS ILLNESS None</p>		<p>PREVIOUS SURGERY None</p>	
<p>SMOKING Yes</p>		<p>DRINKING Yes</p>	
<p>DIET Regular</p>		<p>EXERCISE Regular</p>	
<p>ALLERGENS None</p>		<p>TOBACCO Yes</p>	
<p>ALCOHOL Yes</p>		<p>DRUGS None</p>	
<p>PHYSICIAN Dr. J. H. Smith</p>		<p>PATHOLOGIST Dr. A. B. Jones</p>	
<p>REPORTING PHYSICIAN Dr. J. H. Smith</p>		<p>REPORTING PATHOLOGIST Dr. A. B. Jones</p>	
<p>DATE OF REPORT 1-26-1950</p>		<p>PLACE OF REPORT Baltimore, Md.</p>	



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CERTIFICATE OF DEATH

Reg. Dist. No.

10270

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland. b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Deer Park,		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural Deer Park,	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6 Mi So. Deer Park, Md.		d. STREET ADDRESS 6 Mi. So. Deer Park, Md.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Harry Middle Cornelius Last Shaffer		4. DATE OF DEATH Month September Day 1 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 16, 1893
9. AGE (In years last birthday) 65		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Benjamin F. Shaffer		14. MOTHER'S MAIDEN NAME Lula Elsey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 218-16-4063	
17. INFORMANT Mrs. Harry C. Shaffer		Address R.D. Deer Park, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma body of pancreas DUE TO with metastasis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 157X (c) 1 year			INTERVAL BETWEEN ONSET AND DEATH 1 year
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/11/58 to 9/1/59 , that I last saw the deceased alive on 8/16/59 , and that death occurred at 6:00 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 101 Third Street DATE SIGNED 2 Sept 59			
ACTUAL SIGNATURE Andrew E. Mance M.D.		PHYSICIAN'S NAME (Type) Andrew E. Mance, M. D. Oakland, Maryland.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/4/1959	
22c. NAME OF CEMETERY OR CREMATORY Pleasant Valley Cemetery		22d. LOCATION (City, town, or county) (State) near Oakland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE H. C. Leighton		ADDRESS Oakland, Md.	
24a. REC'D BY REGISTRAR SEP 8 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hines	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10254

Reg. Dist. No.

10271

1. PLACE OF DEATH a. COUNTY <u>Garrett</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Garrett</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>708 Brookfield Avenue</u>			c. LENGTH OF STAY IN 1b <u>Lifetime</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland, Maryland</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Garrett County Memorial Hospital</u>				d. STREET ADDRESS <u>Oakland, Maryland</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>Paul</u> Last <u>Smith</u>				4. DATE OF DEATH Month <u>9</u> Day <u>20</u> Year <u>19 59</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6/23/23</u>		9. AGE (In years last birthday) <u>36</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Car Man</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>		11. BIRTHPLACE (State or foreign country) <u>Cumberland, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Smith, Harry W.</u>				14. MOTHER'S MAIDEN NAME <u>Sanders, Pauline</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>War II</u>				16. SOCIAL SECURITY NO. <u>218-16-4822</u>		17. INFORMANT <u>Mrs. Harry P. Smith</u> Address <u>Cumberland, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Peritonitis and Toxic Reaction</u> <u>822X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Fat Necrosis, Acute</u> DUE TO (c) <u>Complete transection and separation of Pancreas</u>								INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>5 days</u> <u>5 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Thrown free from auto which over turned on top of him</u>					
20c. TIME OF INJURY Month, Day, Year <u>4:00 p. m. Sept. 15, 59</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Secondary Road (Near) Swanton, Garrett, Md.</u>			
20f. (City or town) (County) (State) <u>Swanton, Garrett, Md.</u>				21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>Herbert H. Leighton</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>Sept. 20, 1959</u>	
EXAMINER'S NAME (Type) <u>Dr. Herbert Leighton (Acting)</u>				22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					
22b. DATE THEREOF <u>9-23-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Burial Park</u>				22d. LOCATION (City, town, or county) (State) <u>Cumberland Marylans</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>James F. Scarpelli</u> ADDRESS <u>Cumberland</u>						24a. REC'D BY REGISTRAR <u>SEP 23 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur R. Thomas</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10255

10272

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Garrett</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oakland,</u> c. LENGTH OF STAY IN lb <u>4 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Garrett County Memorial Hospital</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Garrett</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Oakland,</u> d. STREET ADDRESS <u>9th Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Morris</u> Last <u>Standle</u>		4. DATE OF DEATH Month <u>September</u> Day <u>29,</u> Year <u>1959</u>											
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 21, 1957</u>									
9. AGE (In years last birthday) <u>2</u> yrs. <table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>El Toro, Calif.</u>	
IF UNDER 1 YEAR		IF UNDER 24 HRS.											
Months	Days	Hours	Min.										
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>									
13. FATHER'S NAME <u>James Standle</u>			14. MOTHER'S MAIDEN NAME <u>Elizabeth Goss</u>										
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>---</u>		17. INFORMANT Address <u>Mrs. James Standle</u> <u>Oakland, Md.</u>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia, acute</u> <u>491x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) </div> <div style="width: 15%; text-align: center;"> INTERVAL BETWEEN ONSET AND DEATH <u>days</u> </div> </div> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)													
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)									
20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .											
ACTUAL SIGNATURE <u>James H. Feaster Jr.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED									
EXAMINER'S NAME (Type) <u>James H. Feaster Jr., M. D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		<u>9-29-59</u>									
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>													
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/1/1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Deer Park Cemetery</u>									
22d. LOCATION (City, town, or county) <u>Deer Park, Md.</u>		(State)											
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. E. Leighton</u>			ADDRESS <u>Oakland, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE OCT 1 '59</u>								
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>													

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

CERTIFICATE OF DEATH

Reg. Dist. No.

10256

10273

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Grantsville, Md.		c. LENGTH OF STAY IN lb 20 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ARMITA Middle MAE Last WARNICK		4. DATE OF DEATH Month Sept. Day 5 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 1, 1872
9. AGE (In years last birthday) 87 yrs.		10. IF UNDER 1 YEAR Months 6 Days 10 Hours 0 Min.	11. IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) New Germany, Garrett Co. U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jacob Gnagy		14. MOTHER'S MAIDEN NAME Sara Beachy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) none		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mr. Bruce Warnick, Grantsville, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Complete heart block 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Arteriosclerotic heart disease DUE TO (c) Generalized arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized arteriosclerosis			
INTERVAL BETWEEN ONSET AND DEATH 6 months 10 years			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 1 , 19 55 , to Sept. 5 , 19 59 , that I lost saw the deceased alive on Sept. 4 , 19 59 , and that death occurred at 8:30 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE A. Paige Strong		DATE SIGNED Grantsville, Md. 9/6/59	
PHYSICIAN'S NAME (Type) A PAIGE STRONG, M. D.		Grantsville, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/8/59	
22c. NAME OF CEMETERY OR CREMATORY New Germany		22d. LOCATION (City, town, or county) (State) Rural Grantsville, Garrett, Co.	
23. FUNERAL DIRECTOR'S SIGNATURE Don J. Newman		24a. REC'D BY REGISTRAR DATE SEP 9 '59	
ADDRESS Grantsville, Md/		24b. REGISTRAR'S SIGNATURE Charles E. Kinn	

1

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove companion papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
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2002

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Garrett b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Garrett County Memorial Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland d. STREET ADDRESS Weber Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Lucy Swan Weber		4. DATE OF DEATH Month Day Year September 6 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/12/74
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Milwaukee, Wisconsin
12. CITIZEN OF WHAT COUNTRY? United States		13. FATHER'S NAME Charles A. Swan	
14. MOTHER'S MAIDEN NAME Julia Sanderson		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. 235-34-6414		17. INFORMANT Wilhelm Weber Address Clarksburg, W. Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS UNDERLYING: IMMEDIATE CAUSE (a) Pneumonia terminal 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pteridosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH 3 days 10 days
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	
20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from June 1 , 19 59 , to September 6 , 19 59 , that I last saw the deceased alive on September 6 , 19 59 , and that death occurred at 4:00 PM , from the causes and on the date stated above.	
ACTUAL SIGNATURE A. E. Mance M.D. Oakland Md		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) Dr. A. E. Mance Oakland, Maryland		22a. BURIAL, CREMATION, REMOVAL (Specify) burial	
22b. DATE THEREOF 9/10/1959		22c. NAME OF CEMETERY OR CREMATORY Weber Cemetery	
22d. LOCATION (City, town, or county) Oakland Maryland		23. FUNERAL DIRECTOR'S SIGNATURE Gerald N. Minnich Oakland, Maryland	
24a. REC'D BY REGISTRAR DATE SEP 16 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kraw	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

1904

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

OCCUPATION

EDUCATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF MARRIAGE

PLACE OF MARRIAGE

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

OCCUPATION

EDUCATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF MARRIAGE

PLACE OF MARRIAGE

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

OCCUPATION

EDUCATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

Exhibit